

No. 300
10-47
5-17-39
P 1 3908

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 20720
Registrar's No. 5991

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:
(a) County
(b) City or town. St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 51 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Burton
3. (b) If veteran, name war
3. (c) Social Security No. 3
4. Sex Female race Col
5. Color or race
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased: 10 (Month) 11 (Day) 1889 (Year)

8. AGE: 65 Years 8 Months 22 Days
If less than one day hr. min.

9. Birthplace Tabor, N Carolina
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business
12. Name James Edge
13. Birthplace unknown
14. Maiden name Levinde Edge
15. Birthplace unknown

16. (a) Informant Deebye Dismore
(b) Address 1325 Marquis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/48
(City, town, or county) (Day) (Year)
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Emilio Toney
(b) Address 3129 Lucas

19. (a) JUL 6 1948 (Date received local registrar) (b) J. F. Brack (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2837 Stoddard
21 (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 3
year 1948 hour 6 minute 10 a.m.
21. I hereby certify that I attended the deceased from May 12
1948 to July 3 1948
that I last saw h. er alive on July 3 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Cardiovascular Disease 2. Gangrene of Left Foot Duration Undet.

Due to
Due to
Other conditions None
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy No
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury
23. Signature Oscar L Daniels (M. D. or other)
Address 2601 N Whittier Date signed 7/3/48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Clark Young

Licensed Embalmer No. *3371*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.